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St. Bartholomew's Hospital Journal,

MAY, 1902.

"Æquam memento rebus in arduis
Servare mentem."—Horace, Book ii, Ode iii.

On Bonesetters and Displacements of Tendons.

*A Clinical Lecture delivered by Mr. HOWARD MARSH on
May 7th, 1902.*

(Reported by J. D. HARTLEY.)



ENTLEMEN,—In practice you will encounter disappointments, checks, and worries. "Man is born to trouble as the sparks fly upward." One great bugbear that you will meet is the bonesetter. He is always at the surgeon's elbow, and no one can get away from him. It is well to look this question in the face, and to see how we stand in regard to it; and it will at once

be seen that the regular practitioner is at a disadvantage. He is a member of a profession which is made up of scientific responsible men, who have the honour and credit of their profession at heart, and their own personal character and ability to vindicate. The surgeon wishes to do the best that he can for his patient. The bonesetter is a free lance; he has no profession, no trammels, and he is held back by nothing. He delights in saying, "I know no anatomy." A famous bonesetter used to say, "I know nothing about anatomy. I can cure you, what more do you want?" The bonesetter not rarely makes cures in cases in which the careless surgeon fails. He is haphazard in his method, and trusts to fortune. He goes at it straight; and for one case that he cures he perhaps damages three or four. Yet he may be perfectly conscientious. He considers that there are two separate and distinct branches of healing,—1, surgery; 2, bonesetting. His view is that he knows bonesetting, the surgeon knows surgery. He is fond of saying that the surgeon knows all about the big bones, but he knows nothing of the little ones; and he often makes his position secure and assured by asking the patient for a certificate of indemnity, so that if anything goes wrong he will not be held responsible. A patient comes with an injury to the ankle which has been treated by a surgeon without much benefit. The bonesetter says "the small bone of the ankle is out," and he will put it in, but the foot has been so improperly treated that it is now a very bad case. If he (the bonesetter) had been consulted at first all would have been well, but now something very serious is the matter; so the patient signs the paper, and thinks it is quite fair. In this way, you see, the bonesetters have the advantage.

What sort of people are these bonesetters? They are often well-meaning and honest, but they are quite untrained. A few years ago a bonesetter made statements which induced a patient to bring an action against a doctor for malpraxis. The counsel for the defence handed the bonesetter a tibia and fibula, and asked him to articulate them. This the bonesetter could not do. So he was asked, if he

knew nothing about the normal condition and position of the bones, how he could diagnose when one was "out." He said that his knowledge was "hereditary." The bonesetter has no power or method of diagnosis. He examines, say, an ankle, and says "the bone is out," or sometimes in the case of a shoulder that "the deltoid has slipped round to the front." A patient twists his foot, and remains lame for a long time; the bonesetter says the bone is "out." Or a man wrenches his arm, adhesions form, and for some time after he cannot move it. The bonesetter looks him full in the face, and, with an air of confidence, says the "deltoid has slipped round to the front," a statement which convinces the patient that at last the cause of his difficulty is fully understood.

Some years ago I sent two sound men to a bonesetter. One was supposed to have something the matter with his elbow, and the other something the matter with his ankle. The first was told that the bone of his elbow was "out." So he asked which bone. "Oh," said the bonesetter, "the ulna." In the second case the small bone of the ankle was said to be out. For these consultations ten shillings and sixpence was paid by each patient, and they were told to come back again in a few days' time with two guineas, when the bones would be put in again.

There is no doubt that bonesetters cure a certain number of cases, and for this reason surgeons must think of the matter seriously. In a hunting country, for instance, you may be consulted by some one for some slight injury. You do not quite make out what is the matter, and you let the patient go, telling him he will soon get well. But he does not get well. The patient is not satisfied, and he finds his way to a quack, who cures him, probably by breaking down some adhesions. This is not a satisfactory state of things.

To the public the surgeon must not assume an air of superiority over the bonesetter. He must not say, "The bonesetter is a quack, I am a qualified man." The public rather believe in a bonesetter. The latter at once makes a diagnosis, while the surgeon hesitates. Those in authority are always the people that are discredited. Many prefer to be cured by a bonesetter rather than by a surgeon. The credulous public will swallow anything, and the bonesetter's unhesitating manner and immediate diagnosis impress them.

Now what is the surgeon's part in this question? He must be careful to make a correct diagnosis in these apparently trivial cases. I would especially give you this caution: "Revise your diagnosis." Do not come at once to a cut-and-dried conclusion, and then exercise no further care. You are called up at night to see a big muscular man, who is perhaps intoxicated and unmanageable, and has hurt his shoulder. You make out that it is not dislocated. But you must see the patient again next day and revise your diagnosis. If you have a patient with a dislocation, and

you reduce the dislocation, do not think that there is an end of the matter. That is quite wrong. You must see him later, and, if necessary, manipulate the arm to break down adhesions.

A boy fell down and broke his humerus just above the elbow-joint. It was put up and not looked at for three weeks; then it was taken down, and it was found that the elbow could not be bent. The X rays showed that the lower end of the upper fragment was projecting forwards and preventing flexion. If this case had been looked at earlier and frequently this trouble would have been avoided.

No case must be considered trivial. A sprained ankle is serious, though certainly not so serious as an aneurysm of the aorta. But the one case must be treated just as carefully as the other.

What are the cases that bonesetters cure? One proposition may be put definitely forward. The cases which are cured are those in which there is nothing very much the matter. Serious joint disease cannot be cured by movement. Fibrous ankylosis, when it is extensive, cannot be cured. Cases in which slight adhesions in an otherwise healthy joint have to be broken down are the best cases for bonesetters.

Tubercular joints are not cured by bonesetters. If a tubercular joint is forcibly moved more harm than good is done. It is the same in cases affected with active osteoarthritis. If these joints are wrenched harm is done. Those cases in which sepsis has supervened on parturition and led to firm fibrous ankylosis of a joint are unsuitable, The joint in fact has become a scar.

As a result of active movement the scar is torn through, the joint becomes hot and swollen, exudation is poured out, and the case made very much worse. So in these cases the bonesetter fails.

The cases which are most favourable for treatment by movement are those in which there are slight adhesions outside the joint, but the joint itself is normal.

A few years ago I was myself suffering with a slight attack of gout, and had pain in the shoulder, which gave some inconvenience. I was sure that the shoulder was quite healthy, but that adhesions had formed outside the joint. Mr. Willett moved the joint for me, and I got quite well. In this instance there was certainly no tubercle and no sepsis. It was only that the joint was rendered painful by surrounding adhesions. The bonesetters cure these cases readily enough. Sometimes a fall by wrenching a joint fixed by external adhesions effects a cure in the same way.

Many years ago a gentleman was at Harrogate taking the waters for the relief of a stiff shoulder-joint. The springs were then situated in a field surrounded by a hedge and ditch. One morning when this gentleman was walking in the field a cow playfully attacked him. He attempted to escape by taking a flying leap over the hedge and ditch, at the same time throwing his arms violently up. He not

only escaped from the cow, but from that time regained free movement in his shoulder. This was probably a case of slight adhesions about the shoulder-joint ruptured by the sudden movement of the limb, or, as the bonesetter would say, "the shoulder had gone in." The bonesetter would have cured the patient just as the cow did, and with as little knowledge of the condition to which the pain and stiffness were really due.

A case of a slight sprain may be under your care for many weeks, and be treated with lotions and ointments with no effect, but if manipulation were employed the patient would get well in a very short time.

A young gentleman strained his leg when playing tennis, and the limb remained so painful that he was unable to walk. He was sent to South Africa and back in order to rest the leg. He came back no better. Massage led to no improvement. He then went to a bonesetter, and was cured immediately: for the foot was in a state of slight equinus from some tearing and subsequent adhesions of the fascia about the gastrocnemius. By his wrenching, the bonesetter broke down these adhesions and cured the patient. The bonesetter knew nothing about the gastrocnemius; and for all he knew the plantaris may have slipped round to the front; but there was nothing materially the matter, no serious structural change, so the patient was cured.

A gentleman fell down and hurt his elbow. Synovitis followed, and the arm was put on a splint and kept there not for two or three days, but for a month. When the splint was removed it was found that the elbow was stiff. He was told, however, that it would "get all right." But it did not get all right, so the patient went to a bonesetter, who said "the bone was out," treated it by manipulation, and the result was that in two or three days the patient was quite well.

If this case had been treated by the surgeon with two or three days' rest and then massage and movement, all would have been well. In a case of Colles' fracture the forearm is put up in splints for the usual period. The result to look at is very good, so the doctor bids his patient good-bye. But the wrist is stiff, and in three months' time it is just the same. It is painful, and keeps the patient awake at night, and he cannot hold a pin, or drive, or use his wrist in any way. Now is the surgeon's chance to evade the bonesetter; he should give chloroform and move the joint, and employ massage and douching.

A case of slipped semilunar cartilage with effusion into the knee-joint is taken for a case of simple synovitis, and the patient is told that he will soon get well. But he does not improve; the limb is a little flexed and cannot be extended. He goes to a bonesetter, who knows nothing about the semilunar cartilages, but puts the patient in a chair, stands in front of him, takes hold of the limb, and forcibly bends it up, and then extends it. He does this

vigorously perhaps several times. The patient gets a renewal of his synovitis, but the cartilage has gone in, and in a few days he is quite well.

Some cases of hysterical joints in women are cured. There is no need for mechanical treatment, but the impression made by the bonesetter is often sufficient.

The doctor may go on treating his patient for months with asafetida and galvanism, and telling her mother there is nothing the matter with her. The bonesetter comes, as a vigorous and peremptory personality, and cures her.

Now as to the slipping of muscles to which I have already referred. The public believe in this as a frequent accident, and the bonesetters make a great point of it. They say, *e. g.* that the hamstrings have slipped round.

How often do muscles and tendons slip, and what muscles and tendons are they?

First of all it must be clearly understood that it is one of the rarest accidents in minor surgery. I have not seen more than fifteen instances. So if you feel inclined to diagnose this condition you must think to yourself, "I am probably wrong; and it is something else that is the matter." The clearest instance of slipping of a tendon is that of the peroneus longus. When the foot is turned in the tendon cannot slip out of place. But if in jumping or dancing the foot comes to the ground with some force and in a turned-out position the tendon is pulled out to the edge of the external malleolus, and is there held only by a ligamentous band; but sometimes this band is torn through, and the tendon slips on to the front of the malleolus.

The treatment is to replace the tendon; put the foot in a position of inversion and encase in a light plaster-of-Paris or, better, a leather splint for a month, and use massage and passive movement. The ligament becomes reattached, and the patient gets well.

The tibialis posticus is another tendon which sometimes but very rarely becomes displaced. This runs down on the inner side of the foot to its insertion, slightly grooving the tibia as it passes along. In order that this tendon should slip out, the patient must come down with his foot in an inverted position. I have never met with a slipped tibialis posticus. But I have read of one, that of a French gentleman who fell out of a balloon, and who, in addition to losing his hat, his pince-nez, and the change out of his pockets, slipped his tibialis posticus tendon.

Another muscle that sometimes slips is the popliteus.

A boy came up with supposed hip disease. On examination it was clear that he had no hip disease. But there was pain under the glutei muscles, and the limb was fixed in a position of slight abduction and external rotation. He was thought to be probably suffering from tubercular periostitis of his ilium beneath the external rotator muscles. He was told to rest for three months. At the end of three months he was no better, and was lost sight of. Nothing was heard of him for a year, and then it was found that he

had been to a bonesetter, who had put something "in," and the boy was quite well in a week. A year after the patient was again seen in the same condition as at first. Taking the cue from the bonesetter the limb was manipulated under an anæsthetic, and he was soon quite well.

This was probably a very rare instance of slipping of one of the tendinous divisions of the obturator internus muscle.

The long tendon of the biceps, you remember, passes between the two tuberosities of the humerus. The lesser of the tuberosities is the more prominent. If in the act, for instance, of wringing clothes, the humerus is forcibly rotated out, by the biceps acting as a supinator, the tendon may slip over the inner tuberosity. If not replaced it may acquire a new attachment to the bone. The points in respect to diagnosis are—

1. The forearm is kept flexed in order to relax the muscle.
2. The arm cannot be rotated inwards.
3. Much pain, and sometimes tenderness on pressure over the tendon.

I have never seen one of these cases in practice.

A patient complains of something slipping over his knuckle. This is the extensor communis digitorum slipping to one side or the other as the finger is flexed and extended. In a recent injury the prognosis is usually good if the finger is kept extended on a splint for three weeks.

A girl was looking out of a second-floor window when she suddenly twisted her head in order to look up at her brother at a third-floor window. Her head became suddenly fixed in that position.

A boy was washing one morning, and on twisting his head it suddenly became fixed, and he was unable to move it.

A man was riding a horse in a race, and was leading. He turned his head for a moment to see how near his opponent was, when his head became fixed, and he finished the race looking back over his shoulder.

In all these cases, what happened was that one of the small tendons which are inserted into the prominent tubercles of the transverse processes of the cervical vertebrae slipped out of place.

The treatment consists in putting the patient under the influence of an anæsthetic, and kneading the deep muscles in the side of the neck, and moving the head freely in all directions. I have set right two cases of the kind in this manner.

The muscles mentioned are those which are likely to become displaced. They are muscles which do not run a straight course.

Muscles such as the brachialis anticus, the rectus femoris, and the adductor longus, and many more which run in a straight course, cannot become displaced.

Hepatic Dæmia and Fibrous Degeneration of the Heart.

A Clinical Lecture by Dr. GEE.

(Reported by F. A. BAINBRIDGE.)

IN fibrous degenerations (or scleroses), which are the commonest of all morbid changes, the proper parenchyma of the organs wastes, and the interstitial connecting fibrous tissue increases. Examples of such changes are to be found in cirrhosis of the liver, granular kidney, grey induration of the lung, fibrous degeneration of the heart, arterial sclerosis, and sclerosis of the nervous organs.

The first instance of this change which I shall describe is a case of cirrhosis of the liver. The patient, J. A—, aged 49 years, was admitted to Luke on January 28th, 1902, and died on February 28th. The post-mortem examination showed that the liver weighed 38 oz., was very small, and showed very advanced cirrhotic changes. Its surface was much hobnailed, with green and blue discoloration in places. The section revealed many interlobular strands of fibrous tissue; the portal vein was entirely free from clot; the gall-bladder contained thin bile; no gall-stones were present. The spleen weighed 23 oz., and was very large and soft. The kidneys weighed 16 oz.; their capsules were not adherent, and there was no interstitial change.

The morbid changes in the liver were very extreme, and must have been going on for years, yet the man did not notice anything wrong until his feet began to swell, six weeks before admission. These sclerotic diseases are very insidious in their onset, very slow in progress, and very latent as regards symptoms; thousands of people going about their business have cirrhosis of the liver, contracted granular kidney, and so on.

The patient, however, had noticed that his urine had been dark for six months; and in the earlier stages of cirrhosis it is common for the urine to be scanty, with an abundant deposit of urates, highly coloured by urobilin, which is often passed in large amount.

The swelling of the feet, which was otherwise the first symptom, is not infrequent as an early symptom of cirrhosis of the liver, and often precedes the ascites. The oedema begins about the ankles, and spreads upwards until all the parts of the body below the navel are swollen. It may be described as *hyposarca*. It is probably due to stagnation of blood in the inferior vena cava; but one does not know why this occurs.

Four weeks before admission the belly swelled, and the ascites gradually increased.

Two weeks later the patient had an epileptiform attack, in which he lost consciousness and fell down. When he regained his senses his hands were very weak, and trembling

violently. His speech was affected for two days, but he understood what was said to him. At the same time his skin was noticed to be yellow.

On admission.—The conjunctivæ were slightly yellow. The urine was of a deep colour, and contained much urobilin, but no bile. The abdomen was much swollen, and dilated veins were visible. The navel was protuberant, but no fluctuation could be detected, and there was only slight percussion dulness in the flanks. No organ was palpable. The legs, penis, and scrotum were dropsical. Small ecchymoses were visible in the skin of the neck.

On the day after admission the patient passed into a state of coma without convulsions.

These nervous symptoms, namely, coma and convulsions, exactly resembled those met with in kidney disease, and were undoubtedly due to impurities in the blood. It may be noted that the serum of uræmic blood, when injected into healthy animals, is said to be very poisonous. On the other hand, the urine in cases of chronic nephritis is less poisonous than healthy urine.

The difficulty in supposing that uræmia is due to arrest of the excretory functions of the kidney is found in the fact that in mechanical suppression of urine (anuria) the symptoms which occur do not resemble those of uræmia, and especially noticeable is the absence of coma or convulsions. We must conclude that the nature and source of the uræmic poison are unknown.

In the case of this patient, although he presented the symptoms of uræmia, yet his kidneys were healthy. It seems, therefore, that disease of the liver may lead to uræmia; this condition has been called by Debove "hepatic uræmia." Perhaps it may be partly explained by the fact that one function of the liver is to arrest poisons absorbed from the alimentary canal.

Hepatic uræmia is quite distinct from the malignant jaundice (icterus gravis) which occurs in some liver diseases, *e.g.* acute atrophy of the liver and hypertrophic cirrhosis. In icterus gravis there occur deep jaundice, delirium, hæmorrhage from all parts of the body, albuminuria, pyrexia. The patient (J. A—) was not febrile during his attacks of coma; indeed, his temperature was subnormal throughout the disease until a few hours before death. He was treated as if uræmic, and with temporary success, on the principle that the treatment should be directed to the elimination of the supposed poison.

The abdomen was tapped, and about six pints of fluid were withdrawn. He was fed on as much whey as he would take. Pilocarpine was several times injected subcutaneously, and aperients were given. When the liquid was drawn off the liver and spleen could not be felt.

In three days the patient became much more conscious. His urine, however, was still passed involuntarily, so that its total quantity could not be estimated; but what was saved

contained 4 per cent. urea, so that probably there was no failure in the excretory power of the kidneys.

A fortnight later he again became comatose; he was treated in the same way, and in a day or two became quite conscious and better in all respects. A week later, February 24th, he became half comatose for the third time; pilocarpine was injected; the patient sweated profusely, and on February 26th was quite conscious. On February 27th he became drowsy, and by the following morning he was quite comatose for the fourth time. His temperature, which had hitherto been 97° or 98°, rose to 101° just before death.

The abdomen, which was much distended, was again tapped, but only a few ounces of blood-stained serum were withdrawn. Treatment was unavailing, and the coma continued, with laboured breathing, until death occurred on February 28th.

The second case was W. C—, æt. 47 years, who was admitted to Luke on February 15th.

On admission he was suffering from orthopnoea, with constant shortness of breath, and occasional attacks of severe dyspnoea; pain in the front of the chest, and occasional palpitation of the heart. The fits of dyspnoea sometimes were at intervals of a few weeks, sometimes were twice a day, sometimes woke him up in the night, and were brought on by flatulence or exertion, or without obvious cause. They began suddenly with epigastric pain, followed by a suffocating feeling in the same region, and lasted three or four minutes, but complete recovery did not occur for several hours; there was no pain.

His pulse was irregular, very weak, and sometimes hardly perceptible.

The patient stated that the dyspnoea and palpitation began eighteen months previously.

There were hardly any physical signs relative to the heart; the impulse was impalpable, the sounds weak and irregular, no murmur was heard, and there was no evidence of dilatation.

There was no evidence of any valvular obstruction, and the symptoms clearly pointed to inability of the heart to do its work. It was therefore a reasonable conclusion that the active power of the heart was at fault; and this power resides in the muscular tissues of the heart. A diagnosis was made of "degenerated myocardium."

There are two main forms of myocardial degeneration—fatty and fibrous; the former is more common, but there is no means of distinguishing between them.

The symptoms related mainly to the left side of the heart, and there was no dropsy or other evidence of stagnation in the right heart or venous system. The arteries were rigid and tortuous, and post mortem the cardiac arteries were in the same condition of arterio-capillary sclerosis which had possibly caused the degeneration of the myocardium.

His urine was scanty, very albuminous, and contained casts, and the patient was presumed to be the subject of chronic nephritis, such as is almost always associated with arterio-sclerosis. He had been subject to gout for fifteen years, and had a tophus in the pinna of one ear. He died suddenly.

The post-mortem examination showed that the walls of the heart were very thick, pale, tough, and fibrous; its cavities were much dilated. The valves were natural and competent, the aorta natural, and there was very little atheroma anywhere.

Microscopic examination of the heart showed that the bulk of the heart was made up of fibrous tissue with muscular fibres scattered through it. The kidneys were large, very firm, and the surface was slightly granular.

There is a diathesis (or tendency to some special form of disease) which is very common, but for which it is difficult to find an appropriate name, because we do not understand its nature or its essence. Among the diseases related to or dependent upon this diathesis are gout, gravel, obesity, diabetes, eczema, emphysema of the lungs, chronic nephritis, and arterio-capillary sclerosis. For want of a better name these diseases are often called gouty, but gout is only one form of this diathesis.

The sequence of events in the patient was gout, arterial sclerosis, chronic nephritis, fibrous degeneration of the heart.

The Treatment of Chronic Suppurative Disease of the Middle Ear by the Complete Mastoid Operation.

A Clinical Lecture by A. E. CUMBERBATCH, F.R.C.S.

WING to our increased knowledge of the exact anatomical relations of the parts involved, and to the great improvements in the details of the operation itself, it is now much easier than it was some time ago to decide when it is advisable to expose the mastoid antrum, and throw the iter, attic, and tympanum into one cavity for the cure of chronic suppurative disease of the middle ear.

Theoretically the operation should be performed in every case of chronic discharge in which all simpler means of treatment have been fairly tried and have failed. For what length of time these simpler means should be tried will depend largely on the temperament and experience of the surgeon, and on the special conditions of the individual ear. But although theoretically the question of an operation seems easy enough to answer, yet practically it is not so easy.

Hence, in the present state of our knowledge, it may be useful to mention certain groups of cases in which, speaking generally, radical measures are either inexpedient, or should not be undertaken too hastily.

1. There is a group where the whole or greater part of the membrana tympani has been destroyed, and the mucous lining of the tympanic cavity is greatly hypertrophied (polypoid in fact), but there is no obvious bone disease.

Irrigation, astringent lotions, drying powders, as well as the application of caustics, frequently fail to arrest the discharge; yet a considerable proportion of these cases can be cured by the judicious application of the galvanic cautery.

2. There is another group, in which there is frequent recurrence of the discharge on slight provocation, although the discharge is on each occasion readily arrested. Sometimes there is a permanent perforation of the membrana; in others the perforation closes as soon as the discharge ceases.

Notwithstanding the readiness with which the discharge yields to treatment, many surgeons are of the opinion that the lives of such patients are in considerable danger, and that in all such cases the right treatment is to operate without delay. The majority of the patients here referred to are young, and each recurrence is in the nature of an acute attack. By careful attention to the general health, and by appropriate treatment of the naso-pharynx and ear, the discharge recurs at longer and longer intervals, and ultimately ceases altogether. I have never in a single instance seen grave symptoms arise where such patients were skilfully looked after. Let me add that the frequent recurrence of discharge in those no longer young is a source of grave danger, but here there are generally other indications which determine the advisability of an operation.

3. There is another group where the question for or against an operation is a more difficult one to decide, and should not be too hastily answered in the affirmative.

These are cases of discharge from both ears, in which the hearing is excellent, and there are no symptoms calling for operative interference beyond the discharge. This is neither abundant nor offensive as long as the ears are kept clean, but all attempts to entirely arrest it fail. A simple opening into the mastoid antrum will probably not stop the discharge, and in unskilful hands will considerably impair the hearing. If a complete mastoid operation is performed, it may, and probably will stop the discharge, but it will almost certainly impair the hearing. In such cases, in the absence of positive proof of disease of the bone, it is wiser not to operate.

It must not be imagined that the difficulty under consideration is more or less academic. Such patients are fairly numerous, and the surgeon, in his eagerness to effect a cure, may occasionally forget that, after all, the primary use of an ear is for hearing.

Having briefly referred to the group of cases in which on

the whole I deem it inadvisable or unnecessary to operate, I now turn to the easier task of indicating those in which an operation is not only advisable, but often imperative. No one, I imagine, would hesitate to perform a complete mastoid operation, as a preliminary to further operative measures, where well-marked symptoms of threatened intracranial mischief were present; and yet, if such mischief is to be prevented, the operation must be undertaken in many instances where no urgent symptoms exist, for such operation is meant to be preventative as much as curative.

For instance, in some of the cases of the second group the onset of the discharge is invariably preceded by malaise, slight headache, and rise of temperature, and occasionally mastoid tenderness or discomfort. Although these symptoms usually subside on the establishment of the discharge, they yet indicate very clearly the probability of deep-seated mischief, which may at any moment lead to fatal complications unless radical measures are adopted. When, therefore, there are recurring attacks of this nature, operate.

Again, one sees a certain number of patients who, having experienced no trouble from a "spoilt ear" for many years, beyond an occasional discharge, comparatively suddenly develop marked symptoms of labyrinthine vertigo. It is evident in such cases that either inflammation is spreading to the labyrinth, or some accumulation is exerting undue pressure in that region. If, therefore, simpler remedies fail to afford relief, operate.

There are yet other cases of intermittent discharge where an examination of the meatus reveals masses of sodden epidermis, on the removal of which small granulations are often seen. Inquiry also elicits the information that white shreddy particles are constantly removed by syringing. If this condition is found recurring, though the usual methods of treatment have been pursued, there is great probability of the presence of cholesteatomatous accumulations in the tympanic cavity, and possibly in the mastoid. The danger of delay in such cases is obvious.

It is in "attic" disease, perhaps more than in any others, that the greatest difficulty arises in deciding as to the advisability of an operation. Where a granulation protrudes through the perforation, and is not speedily destroyed by cauterisation or curetting, we should probably best consult the safety of the patient by early recognising the slender chance there is of effecting a cure by any measures short of the radical one. In this class of cases a cure is often effected by ossiculectomy with curetting of the diseased area. This may, therefore, be tried before more radical measures are adopted. Finally one is consulted, at long intervals, for periodic attacks of severe mastoid pain following an attack of purulent catarrh. The cases to which I am referring are peculiar in that the pain commences some time after all signs of mischief in the ear have ceased. There may be a perforation of the membrana, more often there is not, nor is there any proof beyond the

patient's word that there ever has been any discharge from the ear; the hearing, too, may be good. Sometimes the patient affirms that at intervals there is a sensation of discharge passing into the throat from the region of the Eustachian tube, at times offensive to taste. These patients are invariably neurotic, and it is extremely difficult, and sometimes impossible, to be certain whether the pain is only neuralgia chiefly confined to the region of the mastoid, or is due to sclerosing otitis of that bone. When it is possible to make approximately an accurate diagnosis of sclerosing otitis, relief is afforded by a radical operation.

The laws governing vital processes, unlike physical ones, are at present too obscure to permit anyone to dogmatise on the exact course inflammation in a particular area will pursue. Each of us, while drawing largely on the experience of others, must ultimately decide from his own experience what line of treatment seems best in any given case.

I have tried in the remarks I have made to point out the chief indications for your guidance—when to operate and when not to. In the present state of our knowledge it is not possible to lay down definite rules.

In conclusion, let me say that the operation, perfect as it is, is not so easy as it looks. It is often difficult even in skilled hands. It requires lightness of touch, as well as knowledge of anatomical relations. The antrum, although present, is often deeply situated, and if small may be missed; and sometimes the floor of the cranium is so much depressed that it is well-nigh impossible to avoid opening the cranial cavity when removing the outer wall of the attic and aditus. The two chief dangers are wounding the lateral sinus and injuring the facial nerve.

[Mr. Cumberbatch then described in detail the complete mastoid operation, including subsequent skin-grafting, illustrating the various stages of the operation by lantern slides. He also showed by dried specimens and lantern slides the various anatomical relations of the tympanic cavity.]

On Ophthalmic Treatment and Therapeutics.*

An Introductory Lecture by WALTER H. JESSOP.

TAKING the subject of ocular therapeutics for my introductory lecture this year, I wish to present it to you on the broadest lines possible. It has always seemed to me that "treatment" is never enough taught and classified on anatomical and physiological principles. We are too prone to invoke a simple for every disease,—nay more, two or three for each. To some practitioners it would seem that the only drug known in ophthalmic work is atropine, and it is used as a heaven-sent specific for all diseases or conditions of the eyes.

* Introductory Lecture to Course on Ophthalmic Medicine and Surgery, May, 1902.

It has certainly the merit of making the patient appreciate the fact that something is being done for him, as the inconvenience of not being able to use the eye for three or four days for near work is unpleasantly apparent to every one treated with atropine. But this inconvenience to the patient is as nothing compared to the evils its indiscriminate use may entail in the production of glaucoma, which I have seen several times follow its application to an eye affected with slight conjunctival congestion. The worst case of glaucoma I have ever seen was induced by one such application.

The eye, from the ease with which pathological changes can be seen in it, is perhaps the organ on which the effect of drugs can be best appreciated and the action of most of the so-called specifics demonstrated failures. I remember, as if only heard yesterday, one of Dr. Gee's terse clinical sayings on specifics, delivered when I was clerking for him: "I know only two drugs worthy of the name of specifics—mercury for syphilis and quinine for ague,—and the latter is not always a specific."

First I will ask you to consider the methods of giving rest to the eye. The greatest, perhaps, and, as far as I know, the shortest lecture ever delivered in this Hospital was given by Abernethy one evening. Entering the crowded theatre and sitting in silence for a minute or two in his celebrated arm-chair, he looked up and said, "Gentlemen, keep diseased parts quiet; that is all," and then left the theatre, amidst a storm of applause from the assembled students. Those few words were the origin of Hilton's famous work on *Rest and Pain*, and are the Key-stone of Conservative Surgery. To apply them to ophthalmic medicine and surgery I would ask you to consider the local and general conditions to be overcome. Locally, we have to limit and stop the movements of the lids and of the extrinsic and intrinsic ocular muscles, and to shut out light from the sensitive nervous portions, as the retina and the optic nerve.

I would impress on you that, owing to the great activity and close association of the co-ordinated movements and reflexes of the eyes, it is impossible for one eye to be absolutely at rest unless its fellow-eye is so also.

The main factors to be attended to in the general constitutional treatment are primarily the circulation, especially that of the head, and also any condition inducing nerve irritability.

To ensure complete rest to an eye it is necessary that both eyes should be bandaged carefully, so as to prevent the working of the extrinsic muscles of either eye. Light must be kept from entering the eyes, and to do this as far as possible, a graduated pad of cotton wool must be placed over each eye before the bandage is applied. The days of dark rooms are past, I hope, as a routine in the treatment of eye disease; one can always subdue or cut off light by tinted glasses, goggles, or a proper bandage. Light and

air are as necessary for the welfare of the ophthalmic patient as they are for patients suffering from other diseases.

But bandaging and exclusion of light does not necessarily give complete rest to the eye. The intrinsic or intra-ocular muscles, the pupillary and ciliary muscles, may still be active, and these must be placed at rest by atropine or some other mydriatic. Also the circulation of the eye ought to be rendered as far as possible equable, and this can only be done by putting the patient in bed and controlling the general circulation and condition. You should always remember that many of your worst hospital cases come here tired out from want of sleep, exhausted from need of proper and wholesome food, and scarcely able to keep body and soul together. The change that even a night's rest in the healthy and genial atmosphere of our wards, assisted often by a dose of house physic and followed by nutritive food, can make in a broken-down patient is extraordinary. No class of case demonstrates this better than commencing glaucoma, and I have often seen all the symptoms disappear by the morning after such treatment.

This, of course, is an extreme way of inducing complete ocular rest, but it will remind you that in treatment you must remember the general condition of the patient as well as the local methods of treating the eye. It would be almost useless to treat a case of iritis by instilling atropine into the eye unless the general conditions of the patient were at the same time attended to.

In cases needing less complete rest the treatment may be efficaciously carried out by keeping only the affected eye at rest. Take, for example, a case of slight corneal abrasion, which is as a rule a very painful condition; here a carefully applied bandage will give often complete relief without any other treatment.

Less complete rest than that afforded by bandaging the eye may be obtained by the use of shades, tinted glasses, or goggles. Shades are frequently of great service where subdued light is needed. The most efficacious are those shading both eyes, and made of cardboard covered with silk, of stout dull paper, or of black plaited straw. They ought to cover and protect the eye above, in front, and at the sides.

Tinted glasses afford great relief and rest to the eyes in many diseases, and are usually a neutral grey or blue in colour. They vary in tints from a very slight shade of grey or blue to an almost black (electric), and very dark blue. The blue tints make everything appear very cold in hue, and are chiefly used when the quality of the light is to be subdued. The grey have not such a depressing effect, and are ordered when the quantity of light needs reduction. A special kind, called peacock-green or spectrum-blue spectacles, are to be recommended in diseases of the retina, choroid, and optic nerve.

(To be concluded.)

A Case of Severe Internal Hemorrhage.

A NOTE ON THE BILATERAL SWELLING OF THE PAROTID AND SUBMAXILLARY SALIVARY GLANDS DURING THE INTRA-VEINUS INJECTION OF NORMAL SALINE SOLUTION.

By S. R. SCOTT, M.B.(Lond.).

T—was a page boy in an hotel. According to his mother he was an active and clever boy, for he had won a scholarship worth £25 when at school. Owing to straitened circumstances at home, however, he had to give up the scholarship, and seek employment as a page boy. About half an hour before admission into the Hospital he had stepped into a lift as it was moving. He slipped, and his body at the waist was jammed between the car and the shaft of the lift. On being extricated he was carried to the Hospital, and admitted to Sitwell Ward under the care of Mr. Butlin, who was on duty.

When admitted into the ward at 7.30 p.m. the patient was very blanched, and was unable to move his lower extremities. The lips and conjunctiva were bloodless. There was no pulse felt at the wrist. The respiratory movements were regular, but were performed with difficulty. He said he could not breathe, and kept saying, "Doctor, can't you make me breathe?" He lay on his back tossing his head and arms restlessly, but never moved his legs. He was, however, very talkative, and asked that his legs might be moved for him. He was able to give his name and address, and to give an account of the accident. He could not feel a needle thrust into the skin of the abdomen below the umbilicus, or when it was thrust into the legs. Although the back felt unusually supple, there was no deformity of the spinous processes of the vertebrae, and no crepitus was found. The skin over the lower part of the back and buttocks was abraded, but there was no actual external wound anywhere. In the head, neck, and thorax no lesion could be found. There was no wound in the mouth. The abdomen was a little distended, and there was a transverse contusion at the level of the umbilicus. In front the percussion note was natural, but there was dullness in both flanks. The liver and spleen were not palpable. The bladder was not distended. Rapidly the signs of shock increased, the extremities felt cold and clammy, and the respirations became irregular. He once complained of thirst, and asked for a drink. At 8.45 p.m. normal saline solution (one drachm to the pint of water), at a temperature in the funnel of 110° (Fahr.), was injected into the left median cephalic vein. By 9 p.m. nearly three pints of the fluid had been injected. The skin felt warm and dry. The pulse at the wrist was 136 per minute, and there was a trace of pink colour in the lips. The parotid and submaxillary salivary glands began to swell rapidly, so that they formed prominent firm tumours perfectly symmetrical, and the outline of the glands could be distinctly seen on the surface. But the patient did not get well. At 9.15 p.m., when four and a half pints of solution had been injected, the cannula was removed and the vein ligatured. Soon after this the arms ceased to move, the character of the respiratory movements changed, becoming irregular, and he appeared to become unconscious. Almost suddenly breathing became arrested, then he gave a few sighing gasps, and at 9.30 p.m. he was dead.

The post-mortem examination two days later showed extensive intra- and retro-peritoneal hæmorrhage, and a transverse division of the spinal cord at the level of the seventh dorsal vertebra. The enlargement of the salivary glands persisted after death, and their outline was plainly visible on the table. No viscus was lacerated. There was no fracture or dislocation of the spine or pelvis, but the spinal canal was full of blood external to the dura mater. There was a complete division of the cord at the level of the seventh dorsal vertebra. The adjacent part of the cord was quite soft, though its contour was preserved. The rest of the cord was firm, and appeared uninjured. The membranes were intact.

This case is published by Mr. Butlin's kind permission, on account of the peculiar swelling of the salivary glands during the intra-venous injection of the saline solution. Whether it was due to the accumulation of secretory products or to increased blood-supply it is not possible to say; but it would appear to be much more likely due to

the osmotic changes resulting from the large intra-venous injection, and if so may possibly be accounted for in much the same way as is the increase in the activity of the kidneys after infusion.

A Case of Lipoma of the Knee.

By E. H. HUNT, M.B.(Oxon.).



H—, a woman æt. 53, was admitted to President Ward on April 29th, 1902, complaining of pain in the right ankle and a swelling in front of the right knee.

History.—Fifteen years ago she injured the right ankle. Since January, 1902, she has had pain in the foot and ankle. For fifteen years she has also noticed a swelling in front of the right knee. This has given her no pain, and has steadily increased in size.

Present condition.—Both legs are cedematous below the knees. There is slight flat-foot on the right side, and some albuminuria.

Right knee.—There is a globular swelling, about three and a half inches in diameter, extending upwards to the middle of the patella, outwards to the head of the fibula, inwards to half an inch beyond the inner border of the patella, and downwards to the tubercle of the tibia. The skin is normal, and not adherent. The edges of the swelling are well defined. The surface is smooth. The consistency is firm and elastic, and there is a sense of fluctuation all over. The movements of both knees are natural, but there is some creaking. With the right leg extended, on contracting the quadriceps extensor muscle the swelling moves upwards, and is firmly adherent to the ligamentum patellæ.

Diagnosis.—Pre-patellar bursa.

Operation.—Vertical incision over swelling. The subcutaneous tissue was readily separated from the capsule of the swelling except for an area about one inch across to the outer side of the ligamentum patellæ. There the capsule was so intimately adherent to the surrounding structures that an opening was made into the swelling with a view to dissecting it out from the inside. The swelling was found to be a lipoma, surrounded by synovial membrane. The pedicle of the lipoma passed upwards under the patella and arose from one of the ligamenta alaria. The pedicle was ligatured and the lipoma removed. The protruded capsule was then cut away, leaving only sufficient to cover in the opening into the joint.

Recovery was uninterrupted, but the pain in the right foot and ankle continues when the patient is up, and the legs are still cedematous after standing.

I have to thank Mr. Harrison Cripps for his kind permission to publish this case.

On a Case of Post-diphtheritic Stenosis of the Larynx, cured by Thyrotomy.

By H. F. PARKER, M.D.(Cantab.), late House Physician to the Wolverhampton and Staffordshire General Hospital.



SOME notes on the following case may be of interest as illustrating some of the difficulties that are liable to be encountered in the after treatment of a case of diphtheria, where tracheotomy or intubation has been performed.

S. T—, a girl of 11, was admitted into hospital on August 4th, 1901, having been ill for a week previously.

On examination she was found to be suffering from a severe attack of diphtheria, the fauces being swollen and covered with membrane; the glands in the neck were enlarged and tender, but there was no evidence of laryngeal obstruction.

The general condition of the patient was poor, the temp. 103° , the pulse quick.

The urine contained a considerable quantity of albumen—about one third—on boiling.

Shortly after admission she was injected with the anti-diphtheritic serum of the Jenner Institute, receiving no less than 38,000 units between August 4th and August 12th.

In spite of this somewhat heroic treatment her condition became worse, and on August 14th tracheotomy was performed, as a last resort, in order to relieve the exhaustion that was now being caused by obstruction to respiration in consequence of the swelling of the fauces. Though collapsed at first, the patient subsequently rallied; two days later the tube was removed for four hours, and on August 19th it was left out entirely.

She then improved rapidly in general health, but, unfortunately, some two weeks later began to have great dyspnoea, with recession of the chest walls during sleep. This became so serious that on September 4th, after an ineffectual attempt to intubate had been made, it was found necessary to reopen the tracheotomy wound and to insert a tube.

On September 18th intubation was again tried without success, the failure being apparently due to the existence of some stenosis of the larynx. So on this and the following day the stricture was dilated under chloroform by passing various sizes of Lister's urethral silver bougies from below upwards, a fair-sized vulcanite intubation tube being then inserted.

A fortnight later this tube was removed, the patient having been first anaesthetised; on her recovering consciousness, however, spasm of the glottis ensued, and a tracheotomy tube was therefore again introduced.

This process was repeated on more than one occasion with a similar result, the stricture having to be first dilated with flexible pewter bougies, which were found to be more efficient than the silver ones previously employed.

On November 26th it was decided to open the larynx. This was performed under chloroform anaesthesia by prolonging the old tracheotomy incision upwards through the cricoid and thyroid cartilages, the former of which (it may be added) was uninjured at the original operation.

The little hæmorrhage that occurred was easily controlled by pressure.

It was then found that there was considerable stenosis of the larynx opposite the cricoid cartilage, together with much swelling of the mucous membrane close to the vocal cords, and also some cicatrisation at the upper aperture of the larynx. With a small pair of curved scissors all

obstructing tissue was then cut away, including a considerable portion of the vocal cords, it being felt that spasm of the glottis would be likely to again occur were these left intact. A large intubation tube was then inserted, but was found to be valueless, since the lower end of it projected forwards through the wound. It was therefore replaced by a long rubber tube which fitted the trachea tightly, and the upper end of which was brought out through the mouth. A few superficial sutures were then inserted, and the patient was sent back to bed, being able to breathe fairly comfortably through the tube. Three days later the tube was coughed out, but the patient was now able to dispense with it, and, moreover, could phonate fairly well.

Subsequently there was some recurrence of the dyspnoea, necessitating a return to the tracheotomy tube for a few days; but on December 12th this was finally removed, and on January 5th the patient was discharged cured after a stay of five months in hospital.

At this time the wound was soundly healed, respiration was perfect, and phonation was remarkably good, consisting of a loud and somewhat raucous whisper, that could be heard at a considerable distance. The patient, when seen a month later, had had no further trouble.

Remarks.—The case presents many features of interest. In the first place the child received no antitoxin until seen at the end of a week from the commencement of the illness, and though it cannot be said that any visible improvement was caused by the 38,000 units that she ultimately received, yet it may have just turned the scale in favour of her recovery.

Secondly, it is interesting to notice that the dyspnoea did not appear until the tracheotomy tube had been left out for a fortnight or more; also that the stenosis (unlike what I believe to be usually the case) was not a consequence of a division of the cricoid at the operation for tracheotomy.

Thirdly, the case is noteworthy for the fact that intubation alone failed to effect a cure. Though ultimately success by this method might have been attained, it was considered best to proceed at once with the more radical operation. The idea of passing a rubber tube from the mouth to the lower part of the trachea is a new one (so far as I am aware), and was found a distinct advantage, enabling the parts to regain their natural relations to some extent.

I am indebted to Dr. MacMunn for kind permission to publish the notes of this case.

View Day, May 14, 1902.

EACH one who reads the title of this paragraph will doubtless picture to himself those View Days at which he himself has assisted, or call to mind the accounts of previous ones recorded year by year in the JOURNAL. He will perhaps scan these lines without hope of gaining fresh knowledge of this old institution (for all View Days resemble one another as closely as do successive Bank Holidays on Hampstead Heath, and render the task of making readable copy of this subject year by year one of increasing difficulty), but with a desire of renewing acquaintance with the times when as a proud member of the Junior Staff he escorted a bevy of admiring friends round "My Wards," or, as a keen dresser pointed out, "My Patients" to his tender and sympathetic relatives.

The Annual View Day was held on May 14th. The weather, which during the early part of the afternoon was fine and fairly sunny, induced a greater number of visitors to turn up and take their share in what is certainly one of the events of the Hospital year.

The usual round of the Hospital was made by the Treasurer and Governors, one of whom, we hear, has created what must be a record by appearing at forty-three of these functions, but noticed with interest the fact that the roll call for Coborn and Radcliffe was taken on the landing instead of in the wards as has usually been done. So far are we advancing on the road to asepsis.

Following the inspection by the Governors came the even more critical inspection by the many visitors and by the representative of the JOURNAL, who set out with a firm intention of inspecting all the wards of the Hospital, and of conferring without fear or favour the palm on the ward most deserving of honour for its decorations. We must in fairness confess that we failed in our object. Suffice it to say we are convinced that during the afternoon as many different opinions were expressed as to which ward was best decorated as there are wards.

Amongst others may be noted, as much for the beauty of the flowers as for skill in their arrangement, Mary, with white narcissi; Lawrence, pink geraniums; Matthew, yellow tulips in the front ward, violet irises and white narcissi in the back; President, beauteous with sweet-smelling roses and arums; Charity, lovely with massed forget-me-nots; and Coborn, beautifully decked out with buttercups.

One omission we noticed, not altogether with regret, and that is the attempt at colouring the water of the fountain, an attempt which has so often failed in its object, but has resulted in staining the cherubs, who so patiently bear their burden, with Pot. Permang. or methylene blue.

Notes.

THE annual dinner of the Cambridge Graduates' Medical Club was held on May 28th, in the Balmoral Hall, Trocadero Restaurant, and was presided over by Prof. Clifford Allbutt. The dinner was preceded by the annual general meeting for the election of officers. After the toast of "The King" Prof. Allbutt proposed that of "The Club." He made reference to the system of examination for medical degrees at present in existence at Cambridge, and discussed at some length the new regulations recently introduced there. He coupled the toast with the name of the retiring senior secretary, Dr. Morley Fletcher. The latter responded to the toast in a very entertaining speech. Dr. Moore's speech was most amusing, and he proposed the "Health of the Chairman" with his usual wit and felicity of expression.

The attendance was well up to the average, and about sixty members and guests were present.

* * *

GRANTED fine weather, one of the most delightful of the Hospital functions is the Summer Concert, which has been arranged for July 7th. The summer concert brings with it a sense of informality, a suggestion of Cambridge during the May week, to which, no doubt, much of its charm is due.

* * *

CONTRARY to our experience of the last two or three years, there was no rain on View Day until quite late in the afternoon. Possibly this accounts to some extent for the unusually large number of visitors. An intelligent patient counted a hundred and fifty in one ward alone in the course of the afternoon.

* * *

ALMOST every one has read Sir James Paget's essay on "What becomes of the Medical Man?" and a very interesting article was recently published by the *London Hospital Gazette* on the causes which induce men to enter the profession. It appears that about 30 per cent. are the sons of doctors, and breathe the medical atmosphere almost from their birth; another 30 per cent. become medical students almost by chance, or because no other means of making a living is open to them; and a third smaller group adopt the profession from deliberate choice; in fact, some are born to medicine, some achieve medicine, and some have medicine thrust upon them. The article is full of interesting observations, and the writer considers that nowadays the percentage of successes in medicine is higher than Sir James Paget was inclined to believe.

* * *

WE beg to congratulate those Bart.'s men who have just completed the final Fellowship Examination of the College of Surgeons. The list of names, which is given in full elsewhere, represents a very considerable proportion of the total number of passes, and is consequently eminently satisfactory.

* * *

WE understand that the west block is shortly to be closed for two months to allow of various repairs and structural alterations.

* * *

THE Hospital Sports will be held on the L.A.C. Grounds, Stamford Bridge, on Tuesday, June 17th, commencing at 2.30 p.m. There will be a band in attendance, and the admission is free. Frequent trains on the District Railway run to Chelsea or Walham Green, and 'buses pass the ground. Intending competitors should enter their names on the list posted in the Smoke Room. Training tickets can be obtained from A. C. Wilson and G. W. Lloyd, the Secretaries. The events are the same as last year with the exception of a Two Miles Steeplechase (handicap), open to all the hospitals. This is a decidedly good innovation, and it is hoped that it may produce a large entry. Mr. Bruce Clarke is President of the Athletic Club.

* * *

THE United Hospitals Sports are also to be held at Stamford Bridge, on Wednesday, June 25th. The admission is one shilling, and tea can be obtained on the ground. There is to be a tug-of-war between teams of eight from the various hospitals. Entrance fee four shillings; entries to be made by Monday, 23rd.

This ought to produce considerable excitement, and Bart.'s ought to make a good show, to judge by certain of the people seen in the Square any day after lunch. The other events are as last year. We hope to win the Shield again; of last year's team G. M. Levick, J. G. Gibb, B. Hudson, P. Gosse, H. E. Graham, R. C. Berryman, D. M. Stone, and F. S. Lister are available. L. D. Bailey, of St. George's, is the Honorary Secretary.

* * *

OUR ancient institution will be well represented at Henley this year, as R. B. Etherington-Smith is sculling for the Diamonds, and H. U. Gould and H. E. Graham are rowing for Kingston.

We were so unfortunate as to lose the Inter-Hospital Fours this year; no doubt this can be partly attributed to the difficulty of getting together a representative crew.

* * *

WE hear that the following incident occurred in a recent examination in pharmacology at one of our older uni-

versities. A student was asked how he would ascertain whether a patient was improving under treatment by iron. He replied that he would remove a portion of the liver, cut sections of it, and test for iron by means of the Prussian blue test. As a contribution to modern clinical pathological methods we think this ought not to pass unrecorded. The story needs no adornment, though undoubtedly there is a moral to be drawn from it.

Amalgamated Clubs.

CRICKET NOTES.

THE Hospital XI so far this season have not been very successful and we can record only one match as having been won. The weather has been singularly inclement, wickets have been wet or slow, and low scores have been the rule. W. Griffen is an acquisition to the eleven, and we wish him much success in the coming cup ties. He played a good innings of 77 against Virginia Water. J. Eckstein also shows promise of future usefulness in the team.

On Saturday, May 24th, there was a good game against M.C.C. at Winchmore Hill, although the bowlers had much the best of the day. The Hospital batted first, and no one except W. S. Nealor and J. Eckstein made any show against Overton's left-handed bowling, the whole side being out for 87, Overton taking 8 wickets for 35 runs. M.C.C. did not do much better, and 9 were out for 69, but the last wicket managed to take their score to 94, and so won an interesting match. The victory of M.C.C. was due entirely to the fine play of Mr. C. Hulton, who went in last and saved the game. H. E. Stanger-Leathes bowled very well, taking 7 wickets for 32, while of the other Hospital bowlers W. Griffen bowled fairly.

Appended is the score of the match.

SCORES:—1st Innings.

ST. BART.'S.	M.C.C.
H. Griffen, st Humphries, b Overton..... 0	C. B. Hulton, c Anderson, b Stanger-Leathes..... 9
C. F. Nicholas, b Overton... 8	T. A. D. Bevington, c Thurston, b Griffin..... 9
W. S. Nealor, c Muggeridge, b Overton..... 25	J. W. Barry, b Stanger-Leathes..... 3
C. A. Anderson, l-b-w Overton..... 5	Chatterton, c Griffin, b Elliott..... 12
C. M. H. Howell, b Chatterton..... 6	B. O. Bircham, b Stanger-Leathes..... 4
L. V. Thurston, b Overton.. 6	J. G. Howard, b Stanger-Leathes..... 0
J. Eckstein, b Hulton..... 24	S. Mavrogani, b Stanger-Leathes..... 8
C. Elliott, c and b Overton.. 3	A. L. Muggeridge, c Thurston, b Stanger-Leathes..... 0
C. F. Page, c and b Overton 0	Overton, b Stanger-Leathes 0
L. L. Philips, not out..... 3	Humphreys, c and b Page... 17
H. E. Stanger-Leathes, b Overton..... 0	C. Hulton, not out..... 15
Extras..... 7	Extras..... 17
Total..... 87	Total..... 94

SCORES:—2nd Innings.

L. V. Thurston, c Humphries, b Hulton..... 21
C. F. Nicholas, b Bircham..... 7
C. M. H. Howell, c Bircham, b Hulton..... 17
J. Eckstein, not out..... 2
L. L. Philips, b Bevington..... 4
Extras..... 4
Total..... 55

ST. BART.'S v. KING'S COLLEGE.

Played at Honor Oak Park on May 29th, and resulted in an easy win for St. Bart.'s. For the winners L. V. Thurston played a fine innings of 101 not out, and found a useful partner in J. Eckstein. W. S. Nealor also played a useful innings. For King's only R. C. Paris and A. M. Pollard made any stand, the former carrying his bat through the innings.

SCORES.

ST. BART.'S.		KING'S COLLEGE.	
C. M. H. Howell, b Pollard	17	R. C. Paris, not out	69
C. F. Nicholas, c Pollard, b Galbraith	4	J. H. Napher, b Stanger-Leathes	2
W. S. Nealor, c and b Pollard	57	A. M. Pollard, c and b Griffin	54
W. Griffin, b Pollard	6	H. R. Edward, c Eckstein, b Griffin	13
C. A. Anderson, b Paris	31	E. A. Saunders, b Stanger-Leathes	1
G. G. Ellett, b Galbraith	30	C. E. Anderson, b Stanger-Leathes	0
L. V. Thurston, not out	101	C. J. Galbraith, c Howell, b Griffin	1
J. Eckstein, not out	67	E. L. Holland, b Griffin	0
C. Elliott	did not bat.	E. T. Fisher, b Griffin	4
G. B. Page	Innings declared closed.	H. L. Gauntlett, b Griffin	0
A. E. Stanger-Leathes		F. L. Doble, b Stanger-Leathes	4
Extras	30	Extras	18
Total	341	Total	166

BOWLING ANALYSIS.

Overs. Maidens. Runs. Wickets.

Stanger-Leathes	14	3	1	53	4
Page	4	1	14	0	
Griffin	14	3	47	6	
Elliott	3	1	18	0	
Anderson	2	0	16	0	

ST. BART.'S v. EALING.

Played at Ealing, May 31st, and resulted in a win for the home team. As usual the Hospital eleven were rather unlucky.

SCORES.

ST. BART.'S.		EALING.	
W. Griffin, c E. S. Littlejohn, b Kirk	33	F. G. Jolly, b Griffin	0
J. Eckstein, b Baker	3	A. R. Littlejohn, c Nealor, b Page	57
W. S. Nealor, c Lomas, b E. S. Littlejohn	28	E. S. Littlejohn, l-b-w Stanger-Leathes	2
C. M. H. Howell, l-b-w Kirk	17	A. E. Baker, c and b Stanger-Leathes	2
C. A. Anderson, c Lomas, b A. Littlejohn	2	F. C. Kirk, c Ellett, b Stanger-Leathes	8
G. G. Ellett, b A. Littlejohn	1	A. S. Darnboy, b Eckstein	42
C. F. Nicholas, b A. Littlejohn	6	G. H. Lomas, b Eckstein	6
B. Hudson, b Kirk	3	A. J. Weir, b Stanger-Leathes	13
L. S. Phillips, not out	4	A. Macdonald, l-b-w Eckstein	6
G. F. Page, c Baker, b A. Littlejohn	2	G. Jones, b Nicholas	8
H. E. Stanger-Leathes, c E. Littlejohn, b Kirk	0	R. S. Latham, not out	0
Extras	7	Extras	14
Total	106	Total	158

BOWLING ANALYSIS.

Overs. Maidens. Runs. Wickets.

Stanger-Leathes	13	2	1	31	4
Griffin	10	1	37	1	
Page	11	0	36	1	
Howell	2	0	11	0	
Eckstein	9	2	21	3	
Nicholas	2	0	6	1	

LAWN TENNIS CLUB.

ST. BART.'S v. NORTH KENSINGTON.

Played at Winchmore Hill on May 10th, resulting in a win for the Hospital by 6-3.

E. H. Hunt and P. Black—

lost to J. W. F. Beaumont and E. H. Pooley, 3-6, 0-6.
beat A. W. Andrews and A. Anderson, 6-3; 2-6, 6-3.
beat W. Miller and H. Baumgartner, 6-3, 6-3.

F. H. Wood and A. Hamilton—

lost to J. W. F. Beaumont and E. H. Pooley, 1-6, 1-6.
beat A. W. Andrews and A. Anderson, 6-4; 1-6, 6-3.
beat W. Miller and H. Baumgartner, 6-3, 8-6.

J. Stirling-Hamilton and G. H. Orton—

lost to J. W. F. Beaumont and E. H. Pooley, 3-6, 4-6.
beat A. W. Andrews and A. Anderson, 7-5, 6-4.
beat W. Miller and H. Baumgartner, 6-3, 6-4.

ST. BART.'S v. DULWICH PARK.

Played at Dulwich Park on May 24th, and resulted in a win for the Hospital by 8-1.

J. Stirling-Hamilton and C. A. W. Pope—

beat T. Wade and A. Tryson, 6-1, 6-0.
beat M. Eaton and P. Eaton, 6-3, 6-3.
beat H. Martin and H. Richardson, 6-3, 6-0.

A. Hamilton and P. Black—

beat T. Wade and A. Tryson, 6-1, 6-2.
beat M. Eaton and P. Eaton, 6-2; 3-6, 6-2.
beat H. Martin and H. Richardson, 8-6; 4-6, 6-3.

P. W. Lethart and J. H. Lamplough—

lost to H. Martin and H. Richardson, 2-6; 6-3, 7-5.
beat T. Wade and A. Tryson, 9-7, 7-5.
beat M. Eaton and P. Eaton, 6-2, 9-7.

ST. BART.'S v. WINCHMORE CLUB.

Played at Winchmore Hill on May 14th, and owing to weather the match was left drawn greatly in favour of Winchmore Hill by 4-1.

C. A. W. Pope and J. G. Slade—

lost to T. Sewell and K. Green, 9-11, 3-6.
lost to P. Dormer and A. Ransome, one set each.

F. H. Wood and A. Hamilton—

lost to K. Green and T. Sewell, 5-7, 5-7.
beat R. E. Page and G. R. Adams, 6-2, 8-6.

R. Black and R. Page—

lost to P. Dormer and A. Ransome, 2-6, 4-6.
lost to R. E. Page and G. A. Adams, 3-6, 3-6.

ROWING CLUB.

The annual Inter-hospital Four-oared Race took place on May 27th over the usual course, from Putney to Hammersmith. St. Bartholomew's and St. George's were the only crews to enter, the latter winning after a good race. The result would doubtless have been different had it been possible for us to be represented by our full strength, but the difficulties of getting away for practice proved insuperable. Our crew was—J. G. Slade, bow; R. Jamieson, 2; B. Hudson, 3; H. U. Gould, stroke; and F. Whittaker, cox.

Starting at rather the faster stroke, Bart.'s led by a little at first, but St. George's drew clear after three minutes' rowing, and eventually won by three lengths in spite of a good spurt by Gould at the Soap Works.

There were no entries for the Junior Race, which consequently fell through.

Ex Infernis.

THE devil looked up and the devil looked down,
And his tail he twirled
And his tail he curled
And the devil he frowned a frown.

His Flor d'Inferno he puffed away
As he gazed around—it was New Year's Day—
At his fine new pavement, a brave array,
Supplied by Good Resolution and Co.;
And he muttered aloud,
"What a terrible crowd!
Plenty to come but none to go.

"Oh where, oh where is the room to be found
I meant to take over the Underground?
But I'm told the works
Of a Mr. Yerkes
Have dashed my ingenious hopes to the ground.

"If there's no more room I have yet a plan;"
And he chuckled and sucked his thumbs:
"I'll pose as a horrid examiner man;
In horrid suspense at my postern gate,
For eternity waiting, they wait and wait,
For a Viva that never comes."

Then a whispering fear
Rustled close in his ear:
"If the folks who think that it's fine to sin,
But knew the crowds that you have within,
There's a chance, you know, that they might begin,
If they thought, to see
That sin is a coarse mediocrity,
And you won't get so many of them down here."

J. R. R. T.

Reviews.

MEDICAL LECTURES AND APHORISMS. By Dr. GEE, Fellow of the Royal College of Physicians; Honorary Physician to the Prince of Wales; Physician to St. Bartholomew's Hospital. (Smith, Elder, London, 1902.)

"He was a scholar, and a ripe good one."

The manifold discoveries made in bacteriology, chemistry, and morbid histology have turned men's eyes of late rather to the laboratory than to the bedside, whereby, as clinical physicians, we have lost while we have gained. We have, indeed, learnt much of the nature of disease; we have grown able to distinguish what was before confounded; but we have also been led to neglect general views by dwelling much on minute changes, have considered less the patient than the bacteria he entertains, and in training ourselves to the laborious use of unprecise instruments of precision have left educating our naked sense.

It is still true that in far the greater part of cases the older methods of examination, and the patient's constitution, which clinical experience alone can gauge, supply the grounds of the decision. We are right in pursuing the

best and newest methods, wrong in neglecting the older, for they are the more difficult and the surer.

Against this tendency no protest is stronger than the example of Dr. Gee's teaching. It is conspicuous for its reliance upon those signs of disease which ear, eye, and hand can appreciate, and which still inspire a confidence not given to complicated and indirect evidence. Read the essays on bronchitis, asthma, and peritonitis. The types of disease are drawn vividly and accurately. They give confidence. We feel that if he has positively said 'tis so, it will not prove otherwise. Yet he uses but the old tools, and, though he mentions the minuter pathology draws nothing from it for his present purpose. The descriptions are lessons which show how great effects can be produced by a master of simple means, and how subordinate a part is played by minute distinction of causes.

It is another virtue in this little book that it is an education in reasoning. We are often told that medicine has lost its position in the public estimation by willingness to serve without wages. It has lost it still more by our ignorance, prejudice, and folly. Our soft hearts have wrought less harm than our softer heads. Not to count the argument of theologians, which is much warped by the charity inculcated by religion, that usual with physicians is to be compared with that of statesmen alone, for the confidence with which it builds upon the sand, and for its ignorance of all the rules of the art. We follow with the delight of an accustomed pleasure the clarity of Dr. Gee's argument, and the knowledge which defines where evidence ends and fantasy begins.

Take for instance the following:—"Willis thought that convulsive asthma might sometimes proceed from irritation of the pulmonary or thoracic nerves, or of the origin of these nerves in the brain. . . . How often have we not heard similar theories? How often have we not seen them supported by the convincing evidence of one of those fanciful designs of which Dr. Andrew used to say, 'Nature abhors a vacuum, but she abhors a diagram more'?" Dr. Gee's next sentence runs, "This is one of those recondite propositions which can be neither maintained nor refuted," and he says no more about it.

These two things, to observe accurately and to argue truly, are the part of a good scholar, and nothing needs to be added to justify the quotation which heads this review. But there is another quality of scholarship, the reverence for learning, of which this book affords copious evidence. Each page recalls to honour some teacher of past time. Each theme is illustrated not alone from the older physicians, but from the philosophy and literature of the world. And not the thought alone, but even the language of the dead is piously preserved. Dr. Gee's book is a home for lost words. He tends and cares for those which have no other friend, and when a stranger wanders down his text he points with a collector's pride to "porraceous," to "lipuria," to "idio-

syncrism," cherished for Sextus Empiricus his sake, and to, dearest of all, "the wambecothe," or belly sickness. It is pleasant when writing has a savour of its own, and the quiet quaintness of Dr. Gee's diction adds a charm to wisdom.

It was alleged in proof of Wolsey's scholarship that he nobly endowed learning with the booty which by his king's indulgence he tore from his country. Such has not hitherto been Dr. Gee's fate. But he is now a Court official, with, no doubt, similar opportunity for public plunder. It may be he will resist the temptation, but should he not, we will remind him that pardon may be won of this world, and we will nerve our minds to risk his hereafter if he will endow for us a seat of learning worthy of that great man, St. Bartholomew. We are not ambitious; something quiet and tasteful, of about the size of Christ Church, will suit us well.

W. P. HERRINGHAM.

ELEMENTARY TEXT-BOOK OF ZOOLOGY. By A. T. MASTERMAN, M.A., D.Sc., F.R.S.E. (Second Edition, 1902. E. and S. Livingstone. 12s. net.)

In this edition some fifty additional illustrations have been added, together with a description of a type of the Rotifera. The first part of the book deals with the general principles of zoology, and contains an excellent summary of such matters. Owing to the necessity for compression this part is not quite as interesting as it otherwise would be, and although quite clear to the more advanced student we expect the beginner will find it rather difficult reading. Perhaps some sections might with advantage have been left out or still further compressed. It is surely a mistake to devote nearly eight pages to Histology (which is usually learnt elsewhere), and only four and a half to the chapter dealing with Heredity and Variation, Evolution and Sexual Selection.

The plan of Part II is excellent. Throughout a number of types are taken from each phylum and described more or less in detail. Then follows a general account of the character of the phylum or sub-phylum as a whole. A good feature is the statement preceding each type, giving its exact position in the scheme of classification. Altogether great care is taken to prevent the student from regarding, as he so frequently does, the different types which he has to get up as so many animals that have no connection with one another.

It is perhaps unfortunate that the author has taken quite so many types as are to be found here. The result is that the description is scarcely as detailed as is necessary for the student who wishes to learn type thoroughly, as is usually necessary in an elementary medical examination. For instance, in the chapter on Annelata we have, in addition to a general *résumé* of the phylum, a description of the following types:—Polygordius, Arenicola, Hirudo, Lumbricus, Nephrops, Blatta, Peripatus, Epeira. Allowing for the very numerous illustrations, these form rather too much subject-matter for the eighty relatively small pages of large print that are assigned to them.

It is always interesting in a book of zoology to see how the author deals with such animals as Balanoglossus, Sagitta, etc. Dr. Masterman very wisely places all such doubtful quantities in one group of Archicœlomata, which includes in addition Echinoderms, Brachiopods, and Polyzoa. The last, by the way, he calls by the Continental name of Bryozoa, the word Polyzoa appearing only in the index.

A large part of the book is devoted to the consideration of types of the Vertebrata, the characteristics of the main groups. The Mammalia specially are dealt with at considerable length, and there is an entire chapter dealing with their distribution. The tendency of the elementary student of zoology to confine his attention almost entirely to Invertebrates has been largely due to the books he has used, and the present work should do much to remedy the fault.

Lastly, the illustrations, of which there are more than 400, are all excellent. Many have been drawn by the author himself from the actual specimens. None are included which will not be of real service to the reader.

GIBSON AND RUSSELL'S PHYSICAL DIAGNOSIS. Third edition, revised and rewritten, by FRANCIS D. BOYD, C.M.G., M.D., F.R.C.P.Ed.

The new edition of this work comprises over 400 pages. The author devotes separate chapters to each of the different systems of the body. He describes in detail the methods available for the physical examination of each system, the alterations which can be detected in disease, and the inferences which may be drawn from these changes.

In addition there are chapters on the special senses, on the examination of the blood, and on clinical bacteriology. The most recent methods of examination that have been devised are carefully described, bringing the book thoroughly up to date.

An ample description of the urine occupies sixty pages, but we are surprised that it contains no reference to the valuable salicyl-sulphonic acid test for proteids and albumoses.

Other omissions occur in the section on the mouth, in which we should have expected a description of the teeth characteristic of inherited syphilis, and some reference to Koplik's spots.

The book is not free from mistakes which might have been avoided by careful proof-reading. Thus we read (p. 23), "Fat may be deficient as a constitutional habit of body, or may be a symptom of wasting disease, and if it should have appeared suddenly it points to the latter as the probable cause." We should not like to accuse the author of meaning what he says.

The following sentence also savours of the occult (p. 227):—"When this infrequent movement of the bowels becomes pathological it is termed *obstipation*." Amongst the causes of obstructive jaundice we are given (p. 21) "pressure on the bile-ducts by external causes, such as accumulation of feces in the bowel." Surely this is a very rare occurrence even in cases of severe obstipation.

In spite of these little shortcomings the book contains such a large amount of valuable information that it cannot fail to be of use to students of medicine, qualified or unqualified.

CLINICAL METHODS. By ROBERT HUTCHISON, M.D., F.R.C.P., and H. RAINY, F.R.C.P.Ed., F.R.S.E. (Second edition. Cassell and Co.)

In the present edition this work has been brought thoroughly up to date, and new chapters have been added on clinical bacteriology and on the examination of pathological fluids. Considerable additions have been made to the chapters on the urine, the nervous system, and the clinical examination of the blood.

For the book as a whole we have nothing but praise; it is a perfect storehouse of information, carefully arranged and clearly set forth, and it cannot fail to be of the utmost value both to the student and to the practitioner.

The methods used in the clinical examination of the circulatory, respiratory, and other systems of the body are systematically described, and the chapters on the urine and on the examination of children are, in our opinion, the best parts of the book, and could hardly be improved upon.

The chapters on the blood and on clinical bacteriology, however, are more open to criticism. The hæmocytometer and hæmoglobinometer of Gowers are nowadays so seldom used that a description of them might well have been omitted. In describing the various kinds of leucocytes the authors do not point out that myelocytes stain very differently with Ehrlich's triacid stain and with eosin and methylene blue; this seems to us a distinction of considerable practical importance.

The chapter on bacteriology is necessarily rather condensed, but we should have thought the anthrax bacillus deserved more than eight lines; moreover it is stated that anthrax occurs principally in wool-sorters, and that the bacillus when found in the blood is as long as a red blood-corpuscle. In our experience in London anthrax almost always occurs in those who work with horsehair; it is well known that anthrax bacilli are rarely found in the blood in man, and that they have an average length of 4 to 5 μ .

Again, the authors state that the typhoid bacillus "occurs in the urine if albuminous." We must absolutely disagree with this statement; albuminuria often occurs in typhoid fever apart from the presence of typhoid bacilli in the urine.

Apart from these and one or two other such statements the book is thoroughly reliable and sound, and we have much pleasure in recommending it to our readers.

Calendar.

- June 13.—On duty. Dr. Gee and Mr. Marsh.
Clinic by Dr. Gee.
- " 14.—S.B.H. Tennis Club v. R.I.E.C., at Egham.
Cricket Club v. Addlestone, at Addlestone.
- " 16.—Special lecture by Dr. Ormerod.
- " 17.—On duty. Sir Dyce Duckworth and Mr. Butlin.
S.B.H. Athletic Club Sports at Stamford Bridge.
- " 18.—Clinic by Mr. Walsham.
S.B.H. Tennis Club v. Chiswick Park, at Chiswick.
- " 19.—S.B.H. Christian Association, Dr. Soltan.
- " 20.—On duty. Dr. Hensley and Mr. Walsham.
Clinic by Sir Wm. Church.
- " 21.—S.B.H. Cricket Club v. H.A.C., at Finsbury.
S.B.H. Tennis Club v. Hornsey, at Hornsey.
- " 23.—Special lecture by Mr. Cumberbatch.
- " 24.—On duty. Sir Lauder Brunton and Mr. Cripps.
- " 25.—Clinic by Mr. Walsham.
S.B.H. Tennis Club v. Wimbledon Park, at Wimbledon.
- " 27.—On duty. Sir Wm. Church and Mr. Langton.
Clinic by Sir Dyce Duckworth.
- " 28.—S.B.H. Cricket Club v. Dunstable, at Dunstable.
S.B.H. Tennis Club v. Albemarle, at Winchmore Hill.
- " 30.—Special lecture by Dr. Ormerod.
- July 1.—On duty. Dr. Gee and Mr. Marsh.
- " 2.—S.B.H. Tennis Club v. Chiswick Park, at Chiswick Park.
Clinic by Mr. Cripps.
- " 3.—S.B.H. Christian Association, Rev. Geo. Tonge.
Shuter Scholarship.
- " 4.—On duty. Sir Dyce Duckworth and Mr. Butlin.
Clinic by Dr. Hensley.
- " 5.—S.B.H. Cricket Club v. East Molesey, at East Molesey.
S.B.H. Tennis Club v. N. Kensington, at Kensington.
- " 7.—Special lecture by Mr. Bruce Clarke.
Summer Concert.
- " 8.—On duty. Dr. Hensley and Mr. Walsham.
- " 9.—Clinic by Mr. Cripps.
- " 10.—Mid-Sessional Address, Abernethian Society.
- " 11.—On duty. Sir Lauder Brunton and Mr. Cripps.
Eighth Decennial Club Dinner at the "Café Royal."
Clinic by Sir Lauder Brunton.
- " 12.—S.B.H. Cricket Club v. R.I.E.C., at Cooper's Hill.

Examinations.

UNIVERSITY OF LONDON.

M.B. Examination.

First Division.—P. G. Harvey.
Second Division.—T. Aubrey, P. J. Cammidge, H. A. Colwell,
F. M. Howell, V. G. Ward.

ROYAL COLLEGE OF SURGEONS.

First Examination for the Fellowship.

J. G. Atkinson, T. Bates, F. Coleman, A. W. D. Coventon,
J. F. Jennings, J. C. Marshall, K. S. Wise, E. E. Young.

Final Examination.

C. G. Watson, T. C. Littler Jones, J. C. Newman, F. P. Connor
C. E. West, F. Barnes, J. H. Henderson, W. Richards, A. Compton.

Appointments.

BAINBRIDGE, F. A., M.B., M.R.C.P., appointed Clinical Pathologist to the Hospital for Sick Children, Great Ormond Street.

BUTCHER, H. H., M.R.C.S., L.R.C.P., appointed House Surgeon to the General Hospital, Birmingham.

CHRISTOPHERSON, J. B., M.A., M.D., B.C.Cantab., F.R.C.S., appointed a Surgeon to the Egyptian Army.

COOKE, R. T., M.R.C.S., L.R.C.P., appointed House Surgeon to the North Devon Infirmary.

SLADE, H. J., M.R.C.S., L.R.C.P., appointed Junior House Surgeon to the Wigan Infirmary.

WARD, H. S., M.B., B.S.Lond., M.R.C.S., L.R.C.P., appointed Second Assistant Medical Officer to the London County Manor Asylum, Epsom.

WILLOUGHBY, W. M., B.A., M.B., B.C., D.P.H.Cantab., appointed Boarding Medical Officer to the Port of London Sanitary Authority.

WILMOT, R. C., M.R.C.S., L.R.C.P., appointed Surgeon to the British India ss. "Golconda."

New Addresses.

CROWTHER-SMITH, T. F., Stanford, Liphook, Hants.
DODSON, G. EVERARD, 16, Stamer Street, Stoke-on-Trent, Staffs.
LANGFORD, C. H., 55, Crouch Hall Road, N.
MACKINTOSH, J. STEWART, "Corner House," Platts Lane, Finchley Road, Hampstead.
MAINGAY, H. B., 33, Queen Street, Scarborough.
MARSHALL, HOWARD, Cirencester, Gloucestershire.
MAYO, T. A., 6, The Parade, Cowes.
WOOD, PERCIVAL, 44, Welbeck Street, Cavendish Square, W.

Births.

MILLEN.—On April 1st, 1902, at Milverton, Malmesbury, Wilts, the wife of Seymour A. Millen, M.R.C.S., L.R.C.P., of a son.
PRATT.—On April 13th, at 36, Windsor Place, Cardiff, the wife of Eldon Pratt, M.D., of a daughter.
WILLOUGHBY.—On May 22nd, at 2, Cumberland Villas, Gravesend, the wife of William Willoughby, B.A., of a son.

Marriages.

DODSON—WELLS.—On April 21st at St. Matthew's, Thorpe Hamlet, Norwich, by the Rev. H. Boyden, B.A., Vicar, George Everard Dodson, second son of George Dodson, Thorpe Hamlet, Norwich, to Emmie Lucy, only child of the late Randall Henry Spencer Wells, Horsham Lodge, Twyford, Hants.
MAINGAY—LEMPRIERE.—On June 3rd at St. James's, Scarborough, by the Rev. J. Hopkin, Henry Bertram Maingay, F.R.C.S., to Kathleen Edith, youngest daughter of the late Captain George Reid Lempriere, R.E., and of Mrs. Lempriere, of Scarborough.